CENTE	RS FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES	456	<u> </u>	FORM	A APPRÓVEI	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ( )	MB NO. 0938-039 (X3) DATE SURVEY		
			A. BUILDI	NG	CO!	MPLETED	
NAME OF F	ROVIDER OR SUPPLIER	445167	B. WING		03	/12/2013	
	RE CENTER OF CRO	SSVILLE	S	STREET ADDRESS, CITY, STATE, ZIP CODE 80 JUSTICE ST			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	10	CROSSVILLE, TN 38555			
PRÉFIX TAG	{EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	AF.	(X5) COMPLETION DATE	
F 272 SS=D	483.20(b)(1) COMF ASSESSMENTS	PREHENSIVE	F 27				
	The facility must co	nduct initially and periodically	:	What corrective action(s) will be accorded for those residents found to have been a	nplished ffected:		
:	reproducible assess functional capacity.	ccurate, standardized sment of each resident's		Resident #164 is no tonger a resident of facility, however, a Minimum Data Set (N significant correction was completed 3/1; submitted 3/19/13.	IDS)	3/19/2013	
	resident assessmer	a comprehensive sident's needs, using the at instrument (RAI) specified ssessment must include at		How will you identify other residents with the potential to be affected by the same of a practice and what corrective action will be	leficient		
	Identification and de Customary routine; Cognitive patterns; Communication;	mographic information;		All current residents with weight loss have potential to be affected. By 4/5/13, MDS (LPNs) audited the most recent MDS assessments to ensure they reflected resaccurate weights.	urses	4/5/2013	
	Continence:	eing; and structural problems;		<ol> <li>What measures will be put into place of what systematic changes will you make to ensure that the deficient practice will not recur?</li> </ol>	·		
	Disease diagnosis a Dental and nutritiona Skin conditions; Activity pursuit; Medications;	nd health conditions; al status;		Weekly, for the next three months, the MI nurses (LPNs) or the Director of Nutrition Services will audit section K of the MDS as Weight Record to ensure the MDS assess reflects the accurate weight.	nd the ment	4/5/2013	
	Special treatments a Discharge potential; Documentation of su the additional assess	mmary information regarding sment performed on the care e completion of the Minimum					
	Documentation of pa	rticipation in assessment.					
30RATORY I	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA		TITLE	-	X6) DATE	
777	- 		Exar	when Dans other	- J	ladia	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PF		): 03/15/2013 1 APPROVED	
CLIVIC	NO FOR MEDICARE	& MEDICAID SERVICES	·		O	MB NO	0938-0391	
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			LE CONSTRUCTION	(X3) DA1	TE SURVEY MPLETED	
		445167	B, WING	š			*****	
NAME OF F	ROVIDER OR SUPPLIER		·			03,	/12/2013	
LIFE CA	RE CENTER OF CROS	SSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 80 JUSTICE ST					
/V /\ 10	SULTANTIV ATA			<u> </u>	CROSSVILLE, TN 38555			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 272	Continued From pag	ge 1	F 2	272	monitored to ensure the deficient	-		
	This REQUIREMEN	T is not met as evidenced			practice will not reoccur; i.e., what quality assurance program will be put into place.			
	the facility falled to a resident's (#164) we residents sampled.	ecord review and interview, accurately assess one sight loss of thirty-five			The Director of Nutrition Services or designerism the MDS and Weight Record auditoreport findings monthly times three months members of the Performance Improvement	and will s to the		
October 15, 2012, w Fibrillation, Congesti Obstructive Pulmona		admitted to the facility on with diagnoses including Atrial live Heart Failure, Chronic ary Disease, Diabetes on, and Compression			Committee. The committee will review the findings and make recommendations if any are found to be deficient. The Performance Improvement Committee includes the Med Director, Executive Director, Ofractor of Nu Pharmacist, Director of Rehab Services, D of Business Development, Business Office Manager, Director of Admissions, Director Environmental Service, Director of Health	y areas lical Irsing, irector		
	(MDS) dated Januar resident was cognitive supervision with set-	erly Minimum Data Set y 9, 2013, revealed the rely intact, required up assistance for eating, and had no weight loss			Information, Director of Recreational Servic Director of Maintenance, Director of Social Services, and Staff Development Coordina		4/5/2013	
	Collection Tool/Nursi 15, 2012, and the Nu signed and dated Oc	al record of the Initial Data ng Services dated October stritional Data Collection Tool stober 17, 2012, by the revealed the weight on pounds.		,			i	
	on January 6, 2013, <sub>1</sub>	t Record revealed the weight was 153 pounds, a loss since admission or						
	Interview with the Re	gistered Dietitian (RD) on				ļ		

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PR	RINTED	03/15/2013
CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			OM		APPROVEE . 0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		445167	B. WING	;		00	(40)D04B
NAME OF F	PROVIDER OR SUPPLIER			STO	EET ADDRESS, CITY, STATE, ZIP CODE	<u>U3</u> ,	12/2013
LIFE CA	RE CENTER OF CROS	SSVILLE		80	) JUSTICE ST		
	i			CI	ROSSVILLE, TN 38555		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE IATE	(X5) COMPLETION DATE
F 272	March 11, 2013, at revealed the RD wa weight data. Furthe Quarterly MDS date reflect the accurate failed to identify the	3:12 p.m., in the activity room, is responsible for the MDS or interview confirmed the d January 9, 2013, did not weight of 153 pounds and weight loss.		272			
	483.20(d), 483.20(k COMPREHENSIVE	CARF PLANS	F 2	:79	F 279		]
	A facility must use the to develop, review a comprehensive plan. The facility must develop for each reside objectives and times medical, nursing, and needs that are ident assessment.  The care plan must to be furnished to at highest practicable posychosocial well-be §483.25; and any see to the resident's §483.10, including the under §483.10(b)(4)	ne results of the assessment and revise the resident's of care.  velop a comprehensive care nt that includes measurable ables to meet a resident's ad mental and psychosocial lifed in the comprehensive describe the services that are tain or maintain the resident's obysical, mental, and sing as required under ervices that would otherwise 483.25 but are not provided exercise of rights under ne right to refuse treatment.			1. What corrective action(s) will be accomp for those residents found to have been affer The Care Plan for Resident #65 was update 3/13/13 by an MDS nurse (LPN) to reflect voloss.  2. How will you identify other residents who the potential to be affected by the same depractice and what corrective action will be to potential to be affected. On 3/15/13, the Will Record for all residents was audited by an impotential weight loss. By 4/5/13, MDS nurse (LPNs) audited current care plans to ensure addressed weight loss as needed.  3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?  Weekly, for the next three months, the Dire Nutrition Services, Registered Dietician, Williams.	ected: led on weight have ficient taken. the eight RN for less e they corrector of ound	3/13/2013 4/5/2013
	by: Based on medical n and interview, the fa-	T is not met as evidenced ecord review, observation, cility failed to care plan a #65) resident of thirty-five			Nurse, Restorative Nurse or designees will Care Plans for residents identified to have values.	weight	4/5/2013

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			01	FORM	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	. 0938-0391 E SURVEY IPLETED
<u> </u>		445167	B. WING	3_		021	12/2013
NAME OF F	ROVIDER OR SUPPLIER	<u> </u>		s	TREET ADDRESS, CITY, STATE, ZIP CODE		1212013
LIFE CA	RE CENTER OF CROS	SSVILLE		ı	80 JUSTICE ST CROSSVILLE, TN 38555		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE .	(X5) COMPLETION DATE
	February 7, 2013, w Chronic Obstructive Cerebrovascular Dir Anxiety, History Fall Stenosis and History Review of the Admis (MDS) dated Februar resident had impalre memory, required st eating, and was 163 or gain. Review of the Admis Flow Sheet dated For revealed 163 pound on February 9, 2013 Review of the Weigl following weights: February 10, 2013, 164 February 17, 2013, 165 February 17, 2013, 165 February 24, 2013, 167 February 25, 2013, 167 February 26, 2013, 167 February 27, 2013, 167 February 28, 2013, 167 February 28, 2013, 167 February 29, 2013, 167 February 2013, 167	ed:  Idmitted to the facility on with diagnoses including Pulmonary Disease, Pulmonary Disease, Sease, Alzheimer's Disease, Sease, Sease, Alzheimer's Disease, Sease, Seas	F	279	4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place.  The Director of Nutrition Services or desig review the Care Plan audit and will report monthly times three months to the member the Performance Improvement Committee committee will review the findings and main recommandations if any areas are found to deficient. The Performance Improvement Committee includes the Medical Director, Executive Director, Director of Nursing, Pharmacist, Director of Rehab Services, Dof Business Development, Business Office Manager, Director of Admissions, Director Environmental Service, Director of Health Information, Director of Recreational Services, and Staff Development Coordinal Services, and Staff Development Coordinal	findings ers of . The ke o be Director of ces,	<i>4/5/2</i> 013

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/15/2013

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES					FORM	: 03/15/2013 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	0	(X3) DAT	. 0938-0391 E SURVEY &PLETED
A		445167	B. WING	3 <u>_</u>				143/2042
	PROVIDER OR SUPPLIER RE CENTER OF CROS	SSVILLE		1 8	REET ADDRESS, CITY, STATE, ZIP COD 30 JUSTICE ST CROSSVILLE, TN 38555	Œ	<u> </u>	12/2013
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	· (X	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 279 F 312 SS=D	Collection/Assessm February 8, 2013, b (RD) revealed "we Weight 160-170#I 154+/-10%Body N weight problems) of height).  Medical record revie being provided Spec (swallow problems).  Observation of the r on March 12, 2013, 2013, at 12:32 p.m., feeding the meal. F one four ounce shall containers of ice cre consumed along wit  Medical record revie February 7, 2013, re not been addressed  Interview with the Di March 12, 2013, at 2 confirmed the care p weight loss. 483.25(a)(3) ADL C/ DEPENDENT RESII  A resident who is un daily living receives	ent signed and dated by the Registered Dietitian sight 163#Usual Body deal Body Weight dass Index (identifies possible 25 (indicated overweight for ew revealed the resident was ech Therapy for Dysphagia esident in the resident's room at 8:00 a.m., and March 13, revealed the resident self urther observation revealed we and two four ounce sem on the tray which were h bites of various food items. ew of the care plan dated evealed the weight loss had rector of Nursing (DON) on 2:00 p.m., in the DON's office, bian failed to address the ARE PROVIDED FOR		279				

DEPARTMENT OF H	EALTH	AND HUMAN SERVIÇES					: 03/15/2013
CENTERS FOR MED	ICARE	& MEDICAID SERVICES					APPROVED . 0938-0391
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	<b>≘</b> S	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				) DAT	E SURVEY RPLETED
		445167	B. WING	;		07/	12/2013
NAME OF PROVIDER OR SU	PPLIER		<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	031	12/2013
LIFE CARE CENTER C	F CROS	SSVILLE		8	30 JUSTICE ST CROSSVILLE, TN 38555		:
PREFIX   (EACH DE	FICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
by: Based on mand interview assistance was resident (#10) The findings Resident #10 February 23, Fibrillation, Ohypertension Obstructive for Medical reconstance and fire continuation, and one person for Observation 8:34 a.m. review matted, oily hands and fire with small for shirt.  Interview with 8:34 a.m., in resident was interview reversed facility had faresident had 11, 2013. Con 11, 2013, in the resident of the continuation of the continu	REMEN  redical II  v, the fa  vl, the fa  color of the  redical II  redical II  redical II  redical II  realed the  request  request	IT is not met as evidenced record review, observation, acility failed to provide ning as ordered for one nirty five residents reviewed.  add:  admitted to the facility on with diagnoses including Atrial ive Heart Failure, etes Mellitus, and Chronic	F	312	1. What corrective action(s) will be accomplisted those residents found to have been affect Resident was given a shower on 3/12/13.  2. How will you identify other residents who have potential to be affected by the same deficient practice and what corrective action will be take All current residents have the potential to be effected. Education provided to nursing staff 4/5/13 by Staff Development Coordinator. Director of Nursing, Assistant Director of Nursing and designees on providing assistance with bathing as ordered.  3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?  The Director of Nursing, Assistant Director of Nursing and designees will audit weekly for the months assistance with bathing by comparing residents' daily shower schedule to the shower skin essessments for each shift to ensure that bathing assistance was provided as ordered.	ed: ave lent ten. aing ithe	3/12/2013 4/5/2013

during the interview informed the resident a

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			Pi		: 03/15/2013 APPROVED
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES				<u> MB NO. 0938-039</u>	
AND PLAN	OF GORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		E CONSTRUCTION		E SURVEY IPLETED
<u> </u>		445167	B. WING	·		03	12/2013
NAME OF F	RÖVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CA	RE CENTER OF CROS	SSVILLE		8	0 JUSTICE ST PROSSVILLE, TN 38555		j
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	וא	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
F 312 F 334 SS=E	shower would be pr Continued interview resident stated "n since I have been in interview revealed to did not provide a be and stated " if the it"  Medical record review February 23, 2013, be showered twice to Record review of the Report Bath reveales showered on March the resident was pro- 11, 2013.  Interview with Licens on March 12, 2013, nursing station, confischeduled for a sho the facility had docu- provided. Continued resident was alert at resident stated it did occur"  483.25(n) INFLUEN	ge 6 ovided during the afternoon. with the resident revealed the ow it's been nearly five days a shower" Continued he resident stated the facility d bath on March 11, 2013, y did I sure don't remember ew of the Care Plan dated revealed the resident was to weekly and as needed.  Seven Day Look Back of the resident was last 8, 2013, (four days prior) and ovided a bed bath on March sed Practical Nurse (LPN) #2, at 8:54 a.m., in the east firmed the resident was wer on March 11, 2013, and mented a bed bath was d interview confirmed the not occur I assume it did not ZAAND PNEUMOCOCCAL	F:	3312	4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place.  The Director of Nursing or designae will not the shower schedule and shower skin assessment audit and will report findings times three months to the members of the Performance Improvement Committee. The Committee will review the findings and make recommandations if any areas are found deficient. The Performance Improvement Committee Includes the Medical Director, Executive Director, Director of Nursing, Pharmacist, Director of Rehab Services, of Business Development, Business Office Manager, Director of Admissions, Director Environmental Service, Director of Health Information, Director of Recreational Services, and Staff Development Coordinates.	eview monthly he ake to be  Director e r of	4/5/2013
	The facility must devithat ensure that — (i) Before offering the each resident, or the	ves education regarding the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER SUPPLIER  LIFE CARE CENTER OF CROSSVILLE  (X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE By JUSTICE ST CROSSVILLE, TN 38556  (X4) TO PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 334  Continued From page 7  (II) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER SUPPLIER  445167  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 80 JUSTICE ST CROSSVILLE, TN 38555  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 334  Continued From page 7  (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	FORM APPROVED MB NO. 0938-0391
LIFE CARE CENTER OF CROSSVILLE  STREET ADDRESS, CITY, STATE, ZIP CODE  80 JUSTICE ST CROSSVILLE, TN 38555  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FRESIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION)  FRESIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION)  FRESIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION)  FRESIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION)  FRESIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE A	(X3) DATE SURVEY COMPLETED
LIFE CARE CENTER OF CROSSVILLE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 334  Continued From page 7  (II) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and  (iv) The resident's medical record includes	03/12/2013
LIFE CARE CENTER OF CROSSVILLE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 334 Continued From page 7  (II) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (III) The resident or the resident's legal representative has the opportunity to refuse immunization; and (IV) The resident's medical record includes  80 JUSTICE ST CROSSVILLE, TN 38555  CROSSVILLE, TN 38555  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BY TAGE OF CROSS-REFERENCED TO THE APPROPRIATE	<u> </u>
F 334  Continued From page 7  (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BIT TAG CROSS-REFERENCED TO THE APPROPRIATION SHOULD BIT TAG (EACH CORRECTIVE ACTION SHOULD BIT TAG (CROSS-REFERENCED TO THE APPROPRIATION	
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	BE COMPLETION
documentation that indicates, at a minimum, the following:  (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and  (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.  The facility must develop policies and procedures that ensure that —  (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;  (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;  (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and  (iv) The resident's medical record includes documentation that indicated, at a minimum, the	acted: ed and Director ; #25; 4/5/2013  o have efficient taken. ment ed an ints or 4/5/2013

DEPART CENTER	MENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	: 03/15/2013 APPRÖVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	. 0938-0391 E SURVEY IPLETED
		445167	B. WING			83/	12/2013
NAME OF F	ROVIDER OR SUPPLIER		_	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		1444
LIFE CAI	RE CENTER OF CROS	SSVILLE			Justice St ROSSVILLE, TN 38555		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(XS) COMPLETION DATE
F 334	representative was the benefits and pot pneumococcal imm (B) That the reside pneumococcal imm the pneumococcal i contraindication or r (v) As an alternative and practitioner recipneumococcal imm years following the timmunization, unless	provided education regarding tential side effects of unization; and unit either received the unization or did not receive mmunization due to medical refusal.  It based on an assessment ormendation, a second unization may be given after 5 first pneumococcal is medically contraindicated or esident's legal representative	F3	334	4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place.  The Director of Admissions or designee wireview the pneumonia documentation audi will report findings monthly times three mothe members of the Performance Improved Committee. The committee will review the findings and make recommendations if any are found to be deficient. The Performance Improvement Committee includes the Med Director, Executive Director, Director of Nu Pharmacist, Director of Rehab Services, D of Business Development, Business Office Manager, Director of Admissions, Director Environmental Service, Director of Health Information, Director of Recreational Service	it and onths to ment y areas e fical ursing, pirector e of	
	by: Based on medical rand interview, the faresident was offered regarding the benefit and received or did immunization for five #95, #35) of five res The findings include Medical record reviet for Pneumococcal V documentation regarding the benefit	d: w of the informed Consent			Director of Maintenance, Director of Social Services, and Staff Development Coordina		4/5/2013

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PR	INTED: (	03/15/2013	
<u>CENTE</u>	RS FOR MEDICARE	& MEDICAID SERVICES			OM	FURM A IB NO O	PPROVED 938-0391	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	·	X3) DATE S COMPL	URVEY	
		445167	B. WING		j	00146		
NAME OF	PROVIDER OR SUPPLIER		<del></del>	OTOGET ADDRESS AND A		03/12	<u> 1/2013</u>	
LIFE CA	RE CENTER OF CROS	SSVILLE	!	STREET ADDRESS, CITY, STATE, ZIP CODE 80 JUSTICE ST CROSSVILLE, TN 38555				
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S F (EACH CORRECTED CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIS FICIENCY)	E C	(XS) COMPLETION DATE	
F 356 SS=C	Review of facility por Pneumococcal Vacor Management, dated "On admissionthe offered if the resider orstatus is unknown providedregarding risksEducation, as administration, and documented"  Interview with the Acceptage of the facility failed to for the facility failed to for the facility failed to for the facility must possed daily basis:  o Facility must possed daily basis: o Facility name, o The current date, o The total number aby the following cate unlicensed nursing sesident care per shire. Registered nurses (a - Certified nurses or Resident census.  The facility must possed practified above on a of each shift. Data in o Clear and readable or consequence of the consequence of the facility must possed field above on a of each shift. Data in o Clear and readable or consequence of the consequence of the facility must possed field above on a of each shift. Data in o Clear and readable or consequence of the consequ	licy, Influenza Vaccine, cine, and Flu Outbreak I December 6, 2007, revealed pneumococcal vaccine is not has not received it while Education benefits and side effects or esessment findings, monitoring are  Iministrator on March 12, nother Activity office, confirmed collow the policy and failed to histration or lack of a pneumococcal vaccine.  NURSE STAFFING  In the following information on	F3	F 358  1. What corrective a for those residents for those residents for those staffing board was updated 3/10/13 data.  2. How will you ident the potential to be all practice and what co All resident have the 3/28/13 the Director leadership to update	ction(s) will be accomplound to have been affect posted in the main consistency of the residents who fected by the same deformative action will be to potential to be affected of Nursing aducated nutte board daily and assigned the board on the	nded: ndg 3/1 have icient aken. I. On rsing sign a	/2013	

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	: 03/15/2013   APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	<u>. 0938-0391</u> E SURVEY PLETED
		445167	B. WING	<u> </u>		03/	12/2013
	PROVIDER OR SUPPLIER RE CENTER OF CROS	SSVILLE	i	8	REET ADDRESS, CITY, STATE, ZIP CODE 80 JUSTICE ST CROSSVILLE, TN 38555		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ( CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	RE	(XS) COMPLETION DATE
F 356	residents and visitor. The facility must, up make nurse staffing for review at a cost standard. The facility must may staffing data for a magnification of the facility must may staffing data for a magnification of the facility must may be staffing data with a constant of the front hall off the nurse staffing data with the lobby, confirmed data was dated Mail current.  483.75(I)(1) RES RECORDS-COMPLIE  The facility must may resident in accordant standards and practical standards and	oon oral or written request, and at a available to the public not to exceed the community aintain the posted daily nurse ninimum of 18 months, or as w, whichever is greater.  IT is not met as evidenced ion and interview, the facility staffing data in a prominent sible to residents and visitors	F:S	356		for o o e iview of y areas e iical iical iiiector of of	4/1/2013

F 514  Continued From page 11 systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to accurately document personal care for one resident (#102) of thirty-five residents reviewed.  The findings included:  Resident was provided personal care 3/12/13 and it was documentad appropriately by a certified nurse aide.  1. What corrective action(s) will be accomplished for those residents found to have been affected: Resident was provided personal care 3/12/13 and it was documentad appropriately by a certified nurse aide.  2. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken.  All current residents have the potential to be affected. Education provided by 4/5/13 to nursing staff (registered nurses, licensed nurses, and certified nurse aides) by Staff Development Coordinator, Director of Nursing, Assistant Director of Nursing and designees on accurately documenting personal care provided.  3. What measures will be put into place or what systematic changes will you make			AND HUMAN SERVICES		PRINTI FOI	:D: 03/15/2013 :M APPROVED
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF CROSSVILLE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR USC IDENTIFYING INFORMATION)  F 514  Continued From page 11 systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REGUIREMENT is not met as evidenced by:  Based on medical record review, observation, and interview, the facility failed to accurately document personal care for one resident (#102) of thirty-five residents reviewed.  The findings included:  Resident #102 was admitted to the facility on	STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	TIPLE CONSTRUCTION (X3) C	ATE SURVEY
STREET ADDRESS, CITY, STATE, ZIP CODE  LIFE CARE CENTER OF CROSSVILLE  SUMMARY STATEMENT OF DEFICIENCIES PREFEX TAGS  (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAGS  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 514  Continued From page 11  Systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided, the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to accurately document personal care for one resident (#102) of thirty-five residents reviewed.  The findings included:  Resident #102 was admitted to the facility on  STREET ADDRESS, CITY, STATE, ZIP CODE 30 JUSTICE ST  ROSSVILLE, TN 38555  CROSSVILLE, TN 385	<u>.                                    </u>		445167	B. WING,		3/12/2013
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION)  F 514  Continued From page 11  systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by:  Based on medical record review, observation, and interview, the facility failed to accurately document personal care for one resident (#102) of thirty-five residents reviewed.  The findings included:  Resident #102 was admitted to the facility on  Resident #102 was admitted to the facility on					STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
FEERX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 514  Continued From page 11 systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by:  Based on medical record review, observation, and interview, the facility failed to accurately document personal care for one resident (#102) of thirty-five residents reviewed.  The findings included:  Resident vas provided personal care 3/12/13 and it was documental appropriately by a certified nurse aide.  9/12/2  F 514  1. What corrective action(s) will be accomplished for those residents found to have been affected: Resident was provided personal care 3/12/13 and it was documented appropriately by a certified nurse aide.  2. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken.  All current residents have the potential to be affected. Education provided by 4/5/13 to nursing staff (registered nurses, and certified nurse aides) by Staff Davalopment Coordinator, Director of Nursing, Assistant Director of Nursing and designees on accurately documenting personal care provided.  The findings included:  Resident was documented appropriately by a certified nurse aides) by 3 faff Davalopment Coordinator, Director of Nursing, Assistant Director of Nursing and designees on accurately documenting personal care provided.  Resident was documented appropriately by a certified nurse aides) by 5 faff Davalopment Coordinator, Director of Nursing, Assistant Director of Nursing and designees on accurately documenting personal care provided.  Resident was documented appropriately by a certified nurse aides) by 5 faff Davalopment Coordinator, Director of Nursing, Assistant Director of Nursing and designees on accurately documenting personal c	LIFE CAS	RECENTER OF CROS	SSVILLE			
systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by:  Based on medical record review, observation, and interview, the facility failed to accurately document personal care for one resident (#102) of thirty-five residents reviewed.  The findings included:  1. What corrective action(s) will be accomplished for those resident sound to have been affected:  Resident was provided personal care 3/12/13 and it was documented appropriately by a certified nurse side.  2. How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be accomplished for those residents found to have been affected:  Resident was provided personal care 3/12/13 and it was documented appropriately by a certified nurse side.  3/12/2/  All current residents have the potential to be affected. Education provided by 4/5/13 to nursing staff (registered nurses, licensed nurses, and certified nurse aldes) by Staff Development Coordinator, Director of Nursing and designees on accurately documenting personal care provided.  The findings included:  3/12/2/  3/1	PREFIX	EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE
Fibrillation, Congestive Heart Failure, Hypertension, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease.  Medical record review of the Admission Minimum Data Set dated March 2, 2013, revealed the resident did not have problems with memory or cognition, and required extensive assistance of one person for activities of daily living.  not recur?  The Director of Nursing, Assistant Director of Nursing, MDS nurses (LPNs) or designees will audit the ADL documentation and compare it with shower skin assessments for residents with a state required Minimum Data Set assessment due during the next three months. Any discrepancies will be addressed via a one-on-one	F 514	The clinical record reinformation to identification to identification to identification to identification to identification to identification and progress notes.  This REQUIREMENT by:  Based on medical read interview, the fadocument personal of thirty-five resident thirty-five resident The findings include Resident #102 was February 23, 2013, Fibrillation, Congest Hypertension, Diabe Obstructive Pulmon Medical record revied Data Set dated Marresident did not have cognition, and requione person for active Observation of the resident did not have cognition and requione person for active Observation of the resident did not have cognition and requione person for active Observation of the resident did not have cognition and requione person for active Observation of the resident did not have cognition and requione person for active Observation of the resident did not have cognition and requione person for active Observation of the resident did not have cognition, and requione person for active Observation of the resident did not have cognition, and requione person for active Observation of the resident did not have cognition, and requione person for active Observation of the resident did not have cognition, and requione person for active Observation of the resident did not have cognition, and requione person for active Observation of the resident did not have cognition.	must contain sufficient ify the resident; a record of the ents; the plan of care and the results of any ening conducted by the State;  IT is not met as evidenced record review, observation, acility failed to accurately care for one resident (#102) ats reviewed.  ed: admitted to the facility on with diagnoses including Atrial tive Heart Failure, etes Mellitus, and Chronic hary Disease.  ew of the Admission Minimum ach 2, 2013, revealed the re problems with memory or ired extensive assistance of rities of daily living.  resident on March 12, 2013, at the resident unshaven, with y skin on the forearms, soiled	F 5	1. What corrective action(s) will be accomplished for those residents found to have been affected Resident was provided personal care 3/12/13 at it was documented appropriately by a certified nurse aide.  2. How will you identify other residents who have the potential to be affected by the same deficiel practice and what corrective action will be taken.  All current residents have the potential to be affected. Education provided by 4/5/13 to nursin staff (registered nurses, licensed nurses, and certified nurse aides) by Staff Development. Coordinator, Director of Nursing, Assistant Director of Nursing and designees on accurated documenting personal care provided.  3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?  The Director of Nursing, Assistant Director of Nursing, MDS nurses (LPNs) or designees will audit the ADL documentation and compare it wishower skin assessments for residents with a state required Minimum Data Set assessment due during the next three months. Any discrepancies will be addressed via a one-on-or-or-or-or-or-or-or-or-or-or-or-or-or-	3/12/2013 e st., 4/5/2013

shirt.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED		
	_	445167	B. WING	·		03 <i>/</i> -	12/2013
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF CROSSVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 80 JUSTICE ST CROSSVILLE, TN 38555			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DBE COMPLÉTION	
F 514	REGULATORY OR LSC IDENTIFYING INFORMATION)		F	514	4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place.  The Director of Nursing or designee will report findings monthly times three month members of the Performance Improvement Committee. The committee will review the findings and make recommendations if a are found to be deficient. The Performant Improvement Committee Includes the Medicient, Director, Director of Pharmacist, Director of Rehab Services, of Business Development, Business Offic Manager, Director of Admissions, Director Environmental Service, Director of Health Information, Director of Recreational Services, and Staff Development Coordination, and Staff Development Coordination.	eview and will as to the ent e ny areas dical lursing, Director ce or of vices, al	4/5/2013

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ 445167 B. WING 03/12/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 80 JUSTICE ST LIFE CARE CENTER OF CROSSVILLE CROSSVILLE, TN 38555 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 514 Continued From page 13 F 514 interview with LPN #3 ( the nurse supervisor on duty on March 11, 2013) by telephone, on March 12, 2013 at 10:00 a.m., revealed on March 11, 2013, "...at approximately 4 p.m. and 8 p.m., the resident declined a shower..." Continued interview confirmed the facility had documented a bed bath had been provided and the facility documentation was not accurate regarding bathing, based on the resident's statements and appearence.

PRINTED: 03/16/2013